

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009244  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 488

FILED FEB 23 1962

VS 300- Rev. 4/59

14002

24000

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94200

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12450

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. - If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>9 HRS.</u>	c. CITY OR TOWN <u>MANCHESTER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Co. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Box 251</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle Last <u>king</u>			4. DATE OF DEATH <u>2-8-62</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HEAVY EQUIP. OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	9. AGE (last birthday) <u>49</u>
11. BIRTHPLACE (City and state or country) <u>ALASKA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN KING</u>		13b. MOTHER'S MAIDEN NAME <u>FLORENCE ?</u>	14. NAME OF HUSBAND OR WIFE <u>ERIS KING</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mrs. James King, Manchester Mo</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Coronary artery stenosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9:40</u> a.m. p.m. Month, Day, Year <u>2-8-62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>CLAYTON</u>	COUNTY <u>Mo.</u> STATE
21. I attended the deceased from <u>2-8-62</u> to <u>2-8-62</u> and last saw him alive on <u>2-8-62</u> Death occurred at <u>9:40 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Albert L. Howe MD</u> (Degree or title)		22b. ADDRESS <u>601 So. Brentwood, Clayton 5</u>	22c. DATE SIGNED <u>2/8/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>2-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>	23d. LOCATION (City, town, & county) <u>Harmandy Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Schrader, Ballwin, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-9-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Not embalmed  
R. Bopp

Licensed Embalmer No. 4584

P. O. Address Bellewin, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.